HANDLING MEDICARE LIENS
and
MEDICAID CLAIMS
(April 2004)

PI-YI MAYO, ATTORNEY AT LAW
5223 GARTH RD.
BAYTOWN, TEXAS 77521
281-421-5774

Nothing in this paper is to be construed as the rendering of legal advice for specific cases, and readers are responsible for obtaining such advice from their own legal counsel. This publication is intended for educational and informational purposes only.

2004 Copyright, Pi-Yi Mayo, All Rights Reserved

TABLE OF CONTENTS

I . WHEN TO WORRY ABOUT A SUBROGATION CLAIM. 3

II. DEALING WITH MEDICARE'S SUBROGATION CLAIM

A. Medicare Secondary Payer Statute 3

B. Attorney Responsibility For Payment Of Medicare Claim 4

III. PROCEDURE FOR PAYING A CLAIM..6

A. Contacting Medicare.. 6

IV. MEDICARE DOESN'T HAVE A CLAIM FOR REIMBURSEMENT...............11

V. MEDICAID CLAIM 11

EXHIBIT 1:
MEDICARE LIABILITY SETTLEMENT CLAIM REIMBURSEMENT SUMMARY 39

EXHIBIT 2:
STANDARD RECOVERY/INITIAL DETERMINATION LETTER TO BENEFICIARY/ATTORNEY 40

EXHIBIT 7:
RELEASE AGREEMENT FORM 43

EXHIBIT 10:
NOTICE TO BENEFICIARY OF MEDICARE'S POTENTIAL RECOVERY 44

EXHIBIT 12:
NOTICE TO ATTORNEY OF MEDICARE'S POTENTIAL RECOVERY 45

I .WHEN TO WORRY ABOUT A SUBROGATION CLAIM.

In most cases the attorney experienced in dealing with public benefits will be brought into a case by a personal injury attorney that is on the verge of settling a case for a client that the PI attorney knows or suspects has been receiving some type of government assistance but is not sure what program provided the benefits and what possible rights of subrogation the government may possess. In these cases the PI attorney is seeking assistance in dealing with these subrogation issues. Upon being contacted by the PI attorney's office, the safest course of action is to not seek to find out from the parties what benefits they have been receiving, as many times they are not sure, but to assume the client received benefits from both Medicare and Medicaid and request confirmation from the governmental entities directly. You should only rely upon the programs to tell you what benefits, if any, the person may have received. In every case the rule is, to assume that we have received benefits and get a written statement from the program telling you the amount of their claim, if any. [1]

II. DEALING WITH MEDICARE'S SUBROGATION CLAIM

Medicare Secondary Payer Statute

" \l 2 The enabling legislation for the Medicare program prohibits Medicare from paying for services to the extent that payment has been made or reasonably can be expected to be made from worker's compensation, liability or no-fault insurance, or employer group health plans. Title 42 Chapter 7 Subchapter XVIII § 1395y(b), 42 CFR 411.20, 42 CFR 411.50 ©). The statute is commonly referred to as the Medicare Secondary Payer Statute (MSP). If payment is made by Medicare because a bill was submitted to Medicare and the existence of the alternate insurer was not know at the time the bill was submitted, the payment is called a Medicare Conditional Payment.[2] Medicare is

---

1

Randal Kauffman, The War of the Cockatrice, 60 Texas Bar Journal No.4 p. 311 April 1997.

2 Medicare Explained 1996, CCH, March 1996 at p. 131. Title 42 Chapter 7 Subchapter XVIII

entitled to seek repayment of the amount paid, less a proportionate share of procurement cost even if the case is settled and the defendant does not admit to any liability. [3] If the claimant receives any payment from the defendant, then Medicare is entitled to repayment. [4] Medicare has both a subrogation claim [5] as well as statutorily created cause of action to collect directly against the "entity" that is required to pay for any such medical care.[6]

§ 1395y(b) (A).

[3] 42 C.F.R. §411.37.

[4] Medicare Explained 1996, CCH, March 1996 at p.at 134.

[5] Title 42 Chapter 7 Subchapter XVIII § 1395y(b)(B) (iii).

[6] *Id. at* § 1395y(b)(B)(ii).

Medicare is only entitled to recover from payments made for medical services. There is no right of recovery for any monies received by the claimant for any damages other than medical bills. If the case is settled without an adjudication by a court or jury, Medicare will disregard any apportionment in the settlement that allocates the monies between pain and suffering or future medical and seek recovery of the full amount of the conditional payment less the procurement costs.[7] It is not possible to escape Medicare recovery by characterizing the settlement as recovery for other than medical bills in the settlement documents.[8]

A. **Attorney Responsibility For Payment Of Medicare Claim**

In a recent publication The Medicare Handbook (2002) from the Center for Medicare Advocacy at page 9-13 the position is taken that an attorney in a personal injury case has no duty to protect Medicare's property interest in a client's personal injury award. The authors note that Medicare takes the position that personal injury attorneys have a statutory obligation to "affirmatively assist Medicare" in recovering conditional payments. In fact, the authors make the case that an attorney is obligated to give the client the proceeds from the settlement if the client so chooses and the Medicare Secondary Payor (MSP) statutes and regulations impose no penalty on the attorney for doing so. (9-14.)

The Medicare Handbook (2002) at page 9-13 and 14 authors explain their position based on a careful reading of the statute and subsequent federal district court rulings. Basically the position is that CMS has wrongfully claimed that the MSP statute gives Medicare claims the status of liens. Second, the case is made that CMS incorrectly asserts that certain punitive powers that exist to punish insurance companies for noncompliance with the MSP claims extend to attorneys as well. The following is the author's attempt to explain the position but this entire section is based on the idea set forth by the authors of aforementioned Handbook.

To evaluate the position taken in the Handbook the statute itself must be carefully viewed. But the premise of the position is not subject to dispute. In a nationwide class action suit *Zinman v. Shalala*[9] the district court ordered Medicare to stop using the term "lien" to describe its reimbursement claim in its collection efforts. The lack of lien status means that an attorney does not owe Medicare any duty to protect its right of recovery. The argument is bolstered by the following facts. The regulations impose a duty on the beneficiary to cooperate with Medicare and if the CMS's recovery action is unsuccessful because the beneficiary does not cooperate, CMS may recover from the beneficiary.[10] The regulations

[7] *Medicare Intermediary Manual §* 3418.7.

[8] Kauffman, *supra*, at 311.

[9] 835 F. Supp. 1163, 1171 (N.D. Cal. 1993), aff'd, 67 F.3rd 841 (9th Cir. 1995).

[10] 42 C.F.R. § 411.23.

impose a duty on 3rd party payers to notify Medicare when a payment is made or should have been made by the 3rd party and the 3rd party learns that Medicare has made a payment. The notice must describe the specific situation and the circumstances including the particular type of insurance coverage and, if appropriate, the time period during which the insurer is primary to Medicare.[11] Further evidence is found in the attempt by CMS to promulgate a regulation that would have imposed a duty on the beneficiary *or his representative* to notify Medicare if an insurance claim was pending but the regulation was never finalized.[12] Since an attorney has no duty to contact or notify or cooperate with CMS it would be difficult to understand how any duty to protect CMS's claim position would supercede the duty that an attorney owes to his or her client. Based on their position the Handbook offers the following advice at page 9-13:

> ....if the client chooses to receive his portion of the insurance proceeds from his attorney and deal with Medicare directly, the MSP statute and regulations impose no penalty on the attorney. Under ethical rules of practice, the attorney should advise his client of MSP recovery program, but the client should then be allowed to decide whether she wants her attorney to pay Medicare directly or disburse the proceeds so that she can handle the MSP claim herself. The client should be advised of the possibility of collection action or termination of future benefits if the MSP recovery claim is not paid. She should also be advised of the possibility of qualifying for a waiver of MSP recovery pursuant to the provisions described above if she received the proceeds from her attorney and used them for necessary items.

The Handbook continues its rationale for its position with an examination and comparison of the specific language of several sections of the regulations dealing with this matter. The regulations impose a duty to reimburse Medicare on the beneficiary or *other party* within 60 days of receiving a third party payment.[13] Other party is described as including physicians and attorneys.[14] Therefore, if the attorney is in possession of liability proceeds then CMS has a right of recovery against the attorney to obtain those proceeds. This section most likely refers to a doctor or hospital that has already been paid by Medicare for a claim and later receives a payment from a third party medical insurance plan. It is difficult to envision a situation where an attorney would receive proceeds from a third party payer and take possession of the monies directly. The only time a attorney is likely to hold such proceeds is in a trust account for the benefit of a client.

---

[11] 42 C.F.R. § 411.25.

[12] 63 Fed. Reg. 14,506 (March 25, 1998).

[13] 42 C.F.R. § 411.24(h).

[14] *Id. at* § 411.25(g) .

Evidence for the position set forth in the Handbook is offered in the statutes and regulations that give Medicare the right to recover against an insurer that has already paid a claim and the ability to collect only the proceeds in the hands of an attorney. The federal statute authorizing a private cause of action against a primary plan empowers Medicare to recover an amount double the amount they are otherwise allowed to collect.[15] A primary plan is defined as a group health plan or large group health plan, a workmen's compensation law or plan, an automobile or liability insurance policy or plan (including a self-insured plan) or no fault insurance. [16] The regulations authorize CMS to recover its payment amount from a "third party payer" even if the payer has already reimbursed the beneficiary or other party.[17] However, as set forth above the regulations only require that an entity reimburse Medicare for any third party payment the entity receives. [18] The same section that requires an entity to reimburse Medicare is subject to the provision in the regulations that reduces Medicare's claim to the amount of the total judgement or settlement minus the party's total procurement costs.[19] This means that even if Medicare seeks to recover the third party payment from an attorney they will still allow the deduction of attorney fees if the claim is disputed. In the past CMS has advanced the position that they could recover the amount of their claim plus additional amounts from a entity such as an attorney. Currently, the Medicare website (see below) warns attorneys of "responsibilities and obligations" they have to report under the MSP that appear to be lacking in the statute and regulations. The website further cautions that Medicare must be paid prior to any disbursements of funds to a client. CMS tells its contractors in the Medicare Intermediary Manual (MIM) at §3418.6 (B)(1) to notify the beneficiary and his or her attorney of his or her responsibility to notify Medicare of both his or her intent to file a claim and of the settlement amount, if a settlement is awarded.

In summary, the position set forth in the Handbook is that because the statues and regulations empower CMS to collect amounts in excess of the conditional payments from third party payers (insurance companies) and does not allow such punitive recoveries from other entities (attorneys) that if an attorney has received a recovery (such as in a trust account) and then disbursed the proceeds to a client minus allowable procurement fees (attorney fees) then the attorney would have no further obligation to Medicare. .

III. PROCEDURE FOR PAYING A CLAIM

[15] Title 42 Chapter 7 Subchapter XVIII § 1395y(b)(3) (A).

[16] Title 42 Chapter 7 Subchapter XVIII § 1395y(b)(2 (A)(ii)

[17] 42 C.F.R. § 411.24(i).

[18] 42 C.F.R. § 411.24(h).

[19] 42 C.F.R. § 411.37

B. **Contacting Medicare**

Once you realize that Medicare may have a claim then the problem becomes how do we find out how much they are claiming we owe and can we negotiate the amount. Because of some fairly recent changes in how Medicare handles the reimbursement process the act of just finding out how much you owe has become complicated.

The Centers for Medicare & Medicaid Services (CMS) formerly known as Health Care Financing Administration (HCFA) has a new initiative to centralize the collection of data for dealing with Medicare Secondary Payment (MSP) issues. The initiative is called Medicare Coordination of Benefits (COB)

The Medicare website at http://cms.hhs.gov/medicare/cob/factsheets/fs_attorneys_msplaws.asp explains the COB program as:

> The purposes of the Medicare Coordination of Benefits (COB) program are to identify the health benefits available to a Medicare beneficiary and to coordinate the payment process to prevent mistaken payment of Medicare benefits. The COB Contractor (COBC) collects, manages, and reports other insurance coverage. The COBC must be notified of situations where medical services rendered to a beneficiary are related to a workers' compensation injury, automobile accident, or other liability because in these instances, another payer has the primary responsibility for payment of medical claims related to the injury. **Both you and your client have significant responsibilities and obligations under the Medicare Secondary Payer (MSP) laws to report these situations**, and your participation is vital in ensuring the integrity of the Medicare Trust Funds. (emphasis added)

On this same website Medicare makes the assertion:

> Medicare's claim must be paid up front out of settlement proceeds before any distribution occurs. Moreover, Medicare must be paid within 60 days of receipt of proceeds from the third party. If Medicare is not repaid in a timely manner, interest may be assessed.

The idea behind COB is to simplify the process for attorneys. The attorney will call a toll-free number and the COB office will direct the attorney to the lead contractor on the case. You are required to give the lead contractor the "adequate lead time" to gather the information but "adequate lead time" is not defined. The lead contractor will gather all of the information for the claim but the contractor will not be able to compromise or waive the claim.

If you are starting a new auto/no-fault, liability, or workers' compensation case or have a general liability question, you can contact the COB office by phone or mail. They have customer service representatives available to provide you with service from 8:00 a.m. to 8:00 p.m., Eastern Standard Time,

Monday through Friday. The toll free number is 1-800-999-1118 and the mailing address for written inquiries is: Medicare-COB, MSP Claims Investigation Project, P.O. Box 5041, New York, New York 10274-5041.

When contacting the COB contractor, you should have the following information:

Your client's name
Your client's Medicare Health Insurance Claim Number (HICN) or Social Security number (SSN)
Date of accident/incident
Description of illness/injury
Name and address of the other insurance (e.g., workers' compensation carrier, auto/no-fault insurance carrier, etc.)
Name and address of legal representative

Upon receipt of this information, the COBC will apply it to your client's Medicare record, assign the case to a Medicare contractor, and inform you and your client of the applicability of the MSP program and Medicare's recovery rights. You will receive a notice advising you of the Medicare contractor assigned to handle the specifics of the case to recovery (i.e., the lead contractor), Medicare's right of recovery, and a beneficiary consent to release form. Once this process is complete, all further inquiries are made through the lead contractor.

The COB contractor (COBC) has another duty as well. Providers of services to Medicare beneficiaries are required to gather information on the specifics of a claim for which they are seeking payment from Medicare. One of the questions that providers are required to ask of a beneficiary is:

> Is the patient receiving treatment for an injury or illness for which another party could be held liable or is covered under automobile no-fault insurance?

If a claim from a provider contains a Trauma/injury diagnosis code it will alert the COBC that an accident or traumatic injury may have occurred and the possibility of an MSP situation warrants development. This process is known as Trauma Code Development (TCD). If information is missing from the claim the COBC will initiate an MSP investigation. This process is intended to alert Medicare to a potential third party liability situation.

As a practical matter although you should go through the process with the COB if you know who your lead contractor is copy them with the letter to COB and it will jump start the claim. Otherwise there will be a needless delay while you deal with the COB that you can eliminate if you have the correct lead contractor.

In Texas, the lead contractor is is Trailblazer Health Enterprises. In years past Trailblazer was behind the requirements set by CMS for handling and responding to claims. Currently they are suppose to be in compliance with CMS guidelines by addressing 7200 separate pieces of correspondence within a 45 day timeframe. The letter should be mailed to:

Trailblazer Health Enterprises
Liability Unit
Box 9020 Denison, Texas 75021
Fax 903-463-0642
Voice: 903-463-0641

The letter must include the following information or it will be returned and further delay your case: [20]

1. The name of the Medicare Beneficiary (the Plaintiff)
2. The beneficiary's HIC number (usually their Social Security Number and can be found on the beneficiary's red, white and blue Medicare Health Insurance Card)
3. Date of the accident or onset of illness involved
4. A description of the accident or illness causing the claim
5. A description of the injuries or medical problems
6. A medical authorization signed by the beneficiary giving Medicare permission to release medical information

Once this letter is received by the lead contractor, a "Notice of Medicare's Potential Recovery" will be sent to the requesting party. In most cases Medicare will take at least 2 months to determine the conditional payment amount. Usually, the PI attorney will be in a hurry to settle the case and get the funds from the defendant. Any action taken in reliance upon the amount that is owed to Medicare without waiting for an official reply from Medicare is apt to be fraught with problems. Medicare will then send a "Notice of Conditional Payment" that will include a list of each claim Medicare has paid to date and a total amount of the conditional payment. The notice states that they will continue to check their records and will keep you informed of any updates. If the timeframe between receiving the Notice of Conditional Payment and payment of the funds is very long, it is important to request a revised conditional payment notice. [21] Until the check is paid to Medicare and a release is obtained, it is possible that the amount of the conditional payment will increase.

[20] Miller, *Handling Liability Cases Involving Medicare*, Elder Law Institute, State Bar of Texas 1996.

[21] *Id.* at B-2.

In the above discussion, mention was made of the amount of the conditional payment being reduced by the "procurement costs".[22] The procurement costs are attorney's fees and expenses incurred in pursing the case. The case must be such that the payments received by the claimant are disputed. Recovery made under PIP or no-fault insurance coverage will not be eligible for a reduction of the Medicare claim unless such payments are in dispute.[23] The calculations concerning how much reduction in the Medicare claim is possible can be very valuable in terms of knowledge for use in planning case strategy or settlement positions; however, the final result will not be known until the actual amount of the settlement is sent to Medicare. Only after receiving the numbers on the final settlement, will Medicare send an "Initial Determination Letter or Demand Letter" which will include their calculations of the reduction allowed for procurement costs. This letter will detail the claims paid by Medicare and the amount they will expect to be paid. Upon settlement of the case, the payment to Medicare should be made within 60 days. If payment is not made within 60 days after the receipt of the funds, then Medicare can charge interest on the amount they deem they are owed.[24] After receipt of payment, if requested Medicare will send a release. If a reason exists that you need to seek a waiver or compromise of the Medicare lien for an amount greater than the procurement costs, it will be impossible to settle the claim at this point with the Contractor. There are three statutory authorities under which Medicare may accept less than the full amount of its claim: Section 1870©) of the Social Security Act, §1862(b) of the Social Security Act, and the Federal Claims Collection Act (FCCA). Each statute contains different criteria upon which decisions to compromise, waive, suspend, or terminate Medicare's claim may be made.[25] Medicare contractors have authority to consider beneficiary requests for waivers under §1870©) of the Social Security Act. Authority to waive Medicare claims under §1862(b) and to compromise claims, or to suspend or terminate recovery action under FCCA, is reserved exclusively to CMS and/or Regional Office staffs.

The process of seeking a further waiver of the claim is a familiar one to those attorneys that have sought a waiver of overpayment in regular Social Security or Social Security Disability cases.[26]

After the amount of the claim has been determined, the settlement of all claims that do not exceed $100,000.00 must be handled by the regional CMS office. Claims in excess of $100,000.00 will be sent to the regional office but will be forwarded to the central office in Baltimore for compromise or

---

[22] *Medicare Intermediary Manual §* 3418.8.

[23] Miller at B-3.

[24] 42 C.F.R. § 411.24 (m) (2) (i).

[25] *Medicare Intermediary Manual §* 3418.13.

[26] Kaufffman, *supra*, at 313.

waiver.

In order to speed up the process it is important to know the procedure the lead contractor will follow. The process has changed since October of 2002. Prior to October of 2002 the lead contractor had access to a list or summary of all of the claims paid on a specific Medicare beneficiary. The computer record was current up to 18 months after the date of the inquiry. If there was a question raised about the bills Medicare was trying to collect as part of the reimbursement claim and the questions were raised more than 18 months after the date of notice to Medicare then the lead contractor would have had to write each of the other contractors handling the claims for an update or summary and request that each individual contractor update the pending claims. The lead contractor is now responsible for handling the claim and is suppose to have a computer record of all of the claims filed by any contractor in the country.

Even though your clients healthcare was delivered in Texas that does not mean that all of the claims filed by providers for the care they received in Texas will be filed with the financial intermediary in Texas. The average case handled by a contractor will involve 2 to 3 different contractors.

IV. MEDICARE DOESN'T HAVE A CLAIM FOR REIMBURSEMENT

Subsequent to the original draft of this paper a case was decided by the 5th Circuit Court of Appeals that has the potential to negate everything set forth above. At the time this article is published the ultimate impact of the case is unknown. The government may appeal the case in which case the ability of CMS to collect on claims will be in limbo until a final ruling on the matter. Currently, because of the ruling in this case it is impossible to settle a claim with CMS. The parties that would normally discuss the settlement of a case have been instructed not to discuss any claim for reimbursement for fear that they will be in contempt of the order by the 5th Circuit Court.

The case is *Thompson v. Goetzman*, No. 02-10198, 315 F.3rd 457, December 17th 2002. The impact and breath of the ruling is being discussed and debated by attorneys throughout the United States at this time. You author will attempt to determine if a consensus exist on the impact of the case pending a final action by the government. The case appears to hold that Medicare does not have a claim for reimbursement against beneficiaries or attorneys that settle with a tortfeasor. Further discussion of the case will be made at the presentation of this paper.

MEDICARE LIEN and MEDICAID CLAIM ISSUE:

Dealing with Medicaid's right of recovery

Medicaid is a needs based program that is available only to person's of limited means as the first part of

this paper makes abundantly clear. Upon signing up for Medicaid benefits the applicant actually assigns any rights of recovery against third parties for payments of medical expenses to the Medicaid. The law governing the entire area of Medicaid's subrogation right can be found at V.T.C.A., Hum. Res. Code § 32.033. Under the current rules the applicant has affirmative duties to inform the Texas Department of Health within 60 days of any unsettled tort claim or of any private accident or sickness insurance coverage or of a potential cause of action that would affect medical needs of the applicant. The failure to fulfil this obligation is a class C misdemeanor. (V.T.C.A., Hum. Res. Code § 32.033 (b). The statute creates a cause of action in favor of the state separate and distinct from any cause of action the applicant may have against a tortfeasor or other party responsible for the medical expenses. [27]

As set forth above, any time your office is involved in this type of case, do not rely on the parties to determine if Medicaid has paid any claims in the case. Contact the agency and get a written reply stating if any benefits were paid and the correct amount of same. The complicating factor in dealing with a Medicaid subrogation claim is that there are two types of claims. One claim is for acute care expenses and the other is for long term care expenses and claims. In order to handle these claims two different offices must be contacted. If you are inquiring about an acute care claim that area is handled by the Texas Department of Health write to them at:

NHIC Medicaid:Attention:Tort
12545 Riata Vista Circle Austin Tx. 78727-6404
FAX-512-514-4225
1-800-846-7307 Tort Section

The regulations on third party recovery by the Texas Department of Health are found at 25 Texas Administrative Code, Chapter 28 , Medicaid Third Party Recovery. The office responsible for handling these matters was changed in September of 2001. Now the attorneys for the Health and Human Services Commission handle third party recovery issues. As of the date of this paper the Texas Administrative Code sections referencing the Department of Health as the enforcement arm for third party recover have not been changed. These sections are in the process of being rewritten but the changes will only concern the agency and not the specifics of the subrogation action. The author of the rules a Ms. Joan Bates a lawyer for the Texas Department of Health has written an article about the process. That article can be found on the website for the Texas Trial Lawyers Association- TTLA at (www.ttla.com). Ms. Bates offered several suggestions in conversations with the author about handling these claims. First, she said most problems can be prevented if the attorney will just read the regulations. It would also be a great help to read her article as well. The regulations at 25 TAC §28.203 require that an attorney representing a client in an action for damages regardless of whether a legal action has been filed that has received medical services paid for by Medicaid must send written

[27] Texas Department of Health, Intervenor v. Martha Buckner and Adolphus Sneed, as Next of Friend of Iesha Buckner, a Minor, 950 S.W. 2d 216 (Tex. Civ. App.–Forth Worth 1997) no writ.

notice of representation within 45 days from the date the attorney undertakes representation of the client or from the date a potential third party is identified.

Second, Ms. Bates offered other advice that is critical. The limit on the amount of attorney fees that can be charged per the regulations prevents an attorney from charging a higher rate to the client per a fee contract on the part of the recovery that is payable to Medicaid. In other words if the amount payable to Medicaid were equal to the entire amount of the recovery Medicaid would take the position that no matter what your agreement with your client, your total fee would be limited to the 15% that the regulations allow. The state takes the position that the amount that you recover for Medicaid and the amount you recover for your client are two legally separate pools of money and on the part that represents the states claim you cannot charge more than 15%. 25 TAC § 28.402 (e). Another important point concerns waiver of any amounts owed to Medicaid. Since Medicaid is a joint Federal and State program it is unlikely that the folks seeking to collect the money will be able to waive the portion of the recovery that is attributable to the Feds claim. The only circumstances that allow the waiver of the entire claim are when the procurement costs would exceed the recovery. Lastly, you cannot escape any part of the claim by how the recovery is characterized. Medicaid will base the amount they demand on the gross amount of any recovery without regard to whether the damages were for pain and suffering or medical bills.

One bright spot that Ms. Bates covers in her article concerns what is called "balance billing." If the doctor or hospital accepted the Medicaid payment then they cannot later bill your client for fees over and above the Medicaid rate. *Young, et al. v. General Motors,* Civil Action No. H-96-1618, Souther Dist. of Texas Houston Division, Sept. 1, 1999. Many times hospitals will bill for the balance of their fees over the Medicaid rate and claim that they have a lien for any third party recovery based on the private pay rate that will be in excess of the Medicaid reimbursement rate. The referenced caselaw holds otherwise as does the contract that providers sign with the State of Texas when they become a providers under the Medicaid program.

If the claim you are seeking to settle is for expenses related to long term care the agency that you must contact is the Texas Department of Human Services. You can reach them at:

Provider Claims Payments —Dept. of Human Services
P.O. Box 149081 Austin Texas 78714-9081
Mail Code Y-948
512-490-4680

Once you have determined the amount of your claim and want to seek a reduction in the claim or a wavier then contact the staff attorney for the Texas Department of Human Services:

Barry Browning – staff attorney at DHS
P.O. Box 2880 Austin, Texas 78714-9030
Mail Code w-615
Phone Number 512-438-3126 ;

Upon reaching a final settlement in the case, the amount of the settlement should be disclosed to NHIC. A release signed by the Medicaid beneficiary should be included with a request for written conformation of the amount of the Medicaid claim. It generally takes about three weeks for the request to be processed; however, it can and does sometimes take longer. Although all final issues should be handled in writing, the staff at NHIC will go over most of the information in a phone conference once the proper release is obtained in their office. As with the Medicare claim, it is possible that the amount of the Medicaid claim can increase during the time the initial contact is made and the final payment is sent. If any significant amount of time passes, it is always prudent to get a revised conformation.

Medicare Basics

Medicare Premium Amounts for 2004

Part A (Hospital Insurance) Premium

Most people do not pay a monthly Part A premium because they or a spouse has 40 or more quarters of Medicare covered employment.

$343.00 per month (Note: This premium is paid only by individuals who are not otherwise eligible for premium-free hospital insurance and have less than 30 quarters of Medicare covered employment).

The Part A premium is $175.00 for those individuals having 30-39 quarters of Medicare covered employment.

Part B (Medical Insurance) Premium

$66.60 per month.

Original Medicare Plan Deductible and Coinsurance Amounts for 2004

Part A: (Hospital Insurance)

Deductible

$876.00 (Per Benefit Period)

Coinsurance

$219.00 a day for the 61st - 90th day each benefit period.

$438.00 a day for the 91st - 150th day for each lifetime reserve day (total of 60 lifetime reserve days - non-renewable).

Skilled Nursing Facility Coinsurance

$109.00 a day for the 21st - 100th day each benefit period.

Part B: (Medical Insurance)

Deductible

$100.00 per year.

U.S. 9th Circuit Court of Appeals

ZINMAN v SHALALA

FLORENCE ZINMAN; VIRGINIA KROPF;

GRACE M. LEE; MARJORIE THOMPSON; MARY BUFFALO; ECIL A. RIDLEY and ADA G. ELLMAN, individually and on behalf of a class of persons similarly situated,

No. 94-15198
D.C. No. CV-90-20674-JW

Plaintiffs-Appellants,

OPINION

v.

DONNA E. SHALALA, Secretary, Health and Human Services, Defendant-Appellee.

Appeal from the United States District Court for the Northern District of California James Ware, District Judge, Presiding

Argued and Submitted September 13, 1995--San Francisco, California

Filed October 5, 1995

Before: Herbert Y.C. Choy, Robert R. Beezer and David R. Thompson, Circuit Judges.

Opinion by Judge Thompson

COUNSEL

Sally Hart Wilson, Center for Medical Advocacy, Tucson, Arizona, and Lenore E. Gerard, Legal Assistance to the Elderly, Inc., San Francisco, California, for the plaintiffs appellants. Matthew M. Collette, United States Department of Justice, Washington, D.C., for the defendant-appellee.

OPINION

THOMPSON, Circuit Judge:

A nationwide class of Medicare beneficiaries who received or will receive lump-sum insurance settlement awards from third parties in connection with Medicare-covered injuries (beneficiaries) appeal the district court's grant of summary judgment in favor of the Secretary of Health and Human Services (HHS). The beneficiaries sued HHS, claiming that under Title XVIII of the Social Security Act, 42 U.S.C.S 1395, et seq., HHS is required to reduce pro rata its recovery of conditional Medicare payments when the beneficiaries' liability settlements are less than their total damages. We have jurisdiction under 28 U.S.C. SS 1291 and 1294, and we affirm.

FACTS AND PROCEDURAL BACKGROUND

This is a class action challenging HHS's interpretation and implementation of the Medicare Secondary Payer provisions of the Social Security Act, 42 U.S.C. S 1395, et seq. As first enacted, Medicare was the primary payer for medical services supplied to a beneficiary, even when such services were covered by other insurance such as an employer group health plan or liability insurance. Responding to skyrocketing Medicare costs, Congress in 1980 enacted the Medicare Secondary Payer legislation (MSP legislation), requiring Medicare to serve as the secondary payer when a beneficiary has overlapping insurance coverage. 42 U.S.C. S 1395y(b).

Under the MSP legislation, when a Medicare beneficiary suffers an injury covered by a group health plan or liability, workers' compensation, automobile, or no-fault insurance, Medicare conditionally pays for the beneficiary's medical expenses. 42 U.S.C. S 1395y(b)(2)(B)(i). If the beneficiary receives a settlement from the primary insurer, Medicare is entitled to reimbursement from the beneficiary for its conditional outlays. 42 U.S.C. S 1395y(b)(2)(B)(ii). HHS has interpreted the MSP legislation to allow full recovery of conditional Medicare payments even when the beneficiary's settlement is for less than her total damages (i.e., a discounted settlement). This interpretation is set forth in 42 C.F.R. S 411.24(c). This regulation provides in pertinent part that the Health Care Financing Administration "may recover an amount equal to the Medicare payment or the amount payable by the third party, whichever is less." Id .

In November 1990, several individual beneficiaries brought suit against HHS challenging the agency's interpretation of the MSP legislation. These plaintiffs were later certified as a class by the district court. They sought an injunction which would require HHS to reduce proportionately its recovery when a beneficiary received a discounted settlement from a third party.

The district court granted HHS's motion for summary judgment. This appeal followed, raising the issue whether HHS is entitled to recover up to the full amount of its conditional Medicare payments when a beneficiary receives a discounted settlement from a third party.

The following hypothetical case illustrates the issue. Assume an accident victim receives a $50,000 settlement. This is the limit of the third-party tortfeasor's liability policy. The victim alleged damages of $80,000 in medical expenses (of which Medicare paid $50,000); $20,000 in property damage; $40,000 in lost wages; and $60,000 in pain and suffering. The total claim for damages is $200,000.

In this hypothetical case, is HHS entitled to recover its entire $50,000 outlay (minus its portion of attorney fees and costs), or must it apportion its recovery, reducing it in proportion to the plaintiff's partial recovery of her total damages claim? The victim in the hypothetical example

recovered only 25% of her claim. According to the beneficiaries' construction of the statute, HHS should recover no more than 25% of its $50,000 outlay ($12,500).

According to HHS's construction of the statute, HHS is entitled to recover its entire $50,000, less applicable attorney fees and costs under 42 C.F.R. S 411.37, subject only to the possibility of a full or partial hardship waiver under 42 U.S.C. S 1395gg(c). 1

DISCUSSION

We review a grant of summary judgment de novo. Jesinger v. Nevada Fed. Credit Union, 24 F.3d 1127, 1130 (9th Cir. 1994). Within this de novo framework, an agency's construction of a statute is reviewed in two steps under the standard established in Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc., 467 U.S. 837, 842 (1984). See also Brandt-Erichsen v. United States Dep't of Interior, 999 F.2d 1376, 1379 (9th Cir. 1993), cert. denied, 115 S. Ct. 92 (1994).

> First, always, is the question whether Congress has directly spoken to the precise question at issue. If the intent of Congress is clear, that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress. If, however, the court determines Congress has not directly spoken to the precise question at
>
> issue, the court does not simply impose its own construction on the statute, as would be necessary in the absence of an administrative interpretation. Rather, if the statute is silent or ambiguous with respect to the specific issue, the question for the court is whether the agency's answer is based on a permissible construction of the statute.

Chevron, 467 U.S. at 842 -43.

The beneficiaries argue that on its face the MSP legislation mandates apportioned rather than full recovery of conditional Medicare payments when a beneficiary receives a discounted settlement. The beneficiaries contend that the MSP legislation's use of the phrase "item or service" specifically limits Medicare's right to reimbursement. The beneficiaries point to 42 U.S.C. S 1395y(b)(2)(B)(i) which provides:"Any payment under this subchapter with respect to any item or service . . . shall be conditioned on reimbursement . . . when notice or other information is received that payment for such item or service has been or could be made . . . [under a workers' compensation law, liability or no fault

insurance]. " 42 U.S.C. S 1395y(b)(2)(B)(i) (emphasis added). The beneficiaries also rely on 42 U.S.C. S 1395y(b)(2)(B)(ii) which provides: "In order to recover payment under this subchapter for such an item or service, the United States may bring an action against any entity which is required or responsible under this subsection to pay with respect to such item or service (or any portion thereof) under a primary plan . . . , or against any other entity . . . that has received payment . . . with respect to the item or service . . . ." 42 U.S.C. SS 1395y(b)(2)(B)(ii) (emphasis added). Because Medicare's recovery is tied to payments for "item[s] and service[s]," the beneficiaries argue that Congress intended to limit Medicare's right to reimbursement to the extent that a beneficiary's settlement actually covers the "item[s] or service[s]" for which Medicare paid.

It is clear from the statute that the references to "item or service" are intended to define the payments for which Medicare has a right to reimbursement. Nothing in this language, however, compels the conclusion that Congress intended to limit the amount of recovery for a conditionally paid "item or service" to a proportionate share of a discounted settlement. The beneficiaries' reliance on 42 U.S.C. SS 1395y(b)(2)(B)(i) and (ii) is misplaced.

The beneficiaries also rely on the subrogation provisions of the MSP legislation. Under 42 U.S.C. S 1395y(b)(1), the United States is subrogated to the rights of individuals or other entities arising under the MSP legislation. This right of subrogation gives HHS the right to be put in the legal position of the beneficiary in order to recover from third parties who are legally responsible to the beneficiary for a loss.

As the beneficiaries note, the right of subrogation is equitable in nature and generally requires application of the equitable principle of apportionment. Under this equitable principle, a subrogated right holder is limited to recovery of the proportion of its loss for which third-party reimbursement is actually received. See 6A Appleman's Insurance Law & Practice, S 4054 (1990). Because HHS is a subrogee, the beneficiaries argue, its recovery must be limited to the pro rata share of an insurance settlement which includes payment for medical expenses. We disagree.

The MSP legislation does not confine the HHS's right of reimbursement to its right of subrogation. The statute grants HHS an independent right of recovery against any entity that is responsible for payment of or that has received payment for Medicare-related items or services, including the beneficiary herself. See 42 U.S.C. S 1395y(b)(2)(B)(ii). This independent right of recovery is separate and distinct from HHS's right of subrogation, see United States v. Travelers Ins. Co., 815 F. Supp. 521, 523 (D. Conn. 1992); Provident Life & Accident Ins. Co. v. United States, 740 F. Supp. 492, 501 (E.D. Tenn. 1990), and is not limited by the equitable principle of apportionment stemming from the subrogation right. Moreover, to define Medicare's right to recover its conditional payments solely by reference to its right of subrogation would render superfluous the alternative remedy of the independent right of recovery contained in section 1395y(b)(2)(B)(ii). We decline to construe the statute in a way that would render clear statutory language superfluous. See Mountain States Tel. & Tel. Co. v. Pueblo of Santa Ana, 472 U.S. 237, 249 (1985).

We reject the beneficiaries' contention that HHS's recovery is limited by the equitable principle of apportionment applicable to the right of subrogation.

Finally, the beneficiaries argue that the "Coordination of Benefits" provision of the MSP legislation requires a proportionate reduction of Medicare's recovery of conditional payments when a beneficiary receives a discounted settlement. We reject this argument.

The coordination of benefits provision of the MSP legislation provides in pertinent part: "Where payment for an item or service by a primary plan is less than the amount of the charge for such item or service and is not payment in full, payment may be made under this title . . . for the remainder of such charge . . . ." 42 U.S.C. S 1395y(b)(4). Nothing in this language limits Medicare's right of full reimbursement. This provision merely provides that Medicare may pay for covered medical expenses not paid by primary insurance. With regard to the amount of reimbursement available to Medicare, whether full or apportioned, the statute is silent.

Although the beneficiaries proffer creative constructions of the MSP legislation, we conclude the statute does not address the issue of apportioned recovery of conditional Medicare payments, either by its language or by its structure.

Because Congress has not "directly spoken to the precise question at issue," Chevron, 467 U.S. at 842 , we turn to the second step of the Chevron analysis and consider whether HHS's construction of the MSP statute is a permissible one. Id. at 843. If HHS's construction is "rational and consistent with the statute," it is a permissible construction and we will uphold it. NLRB v. United Food & Commercial Workers Union, 484 U.S. 112, 123 (1987).

Reading the MSP legislation to allow full reimbursement of conditional Medicare payments even though a beneficiary receives a discounted settlement from a third party is a rational construction of the statute. It is also consistent with the statute's purpose. The transformation of Medicare from the primary payer to the secondary payer with a right of reimbursement reflects the overarching statutory purpose of reducing Medicare costs. See also H.R. REP. NO. 1167, 96th Cong., 2d Sess. 352 (1980), reprinted in 1980 U.S.C.C.A.N. 5526, 5717 (congressional intent motivating MSP legislation was to reduce Medicare costs). A full recovery of conditional payments will reduce such costs.

HHS's construction also provides a practical and economical way for Medicare to recover its conditional payments. In the hypothetical case discussed above, the injured victim alleged a variety of damages, some capable of precise computation, some not. Such allegations are not uncommon. HHS's ability to recover the full amount of its conditional payments, regardless of a victim's allegations of damages, avoids the commitment of federal resources to the task of ascertaining the dollar amount of each element of a victim's alleged damages.

The beneficiaries argue that ascertaining the dollar amounts of a victim's elements of damages is not a

prohibitive burden. They remind us that HHS accepts apportionment of conditional Medicare payments in workers' compensation cases involving particularized components of damages. See 42 C.F.R. S 411.47. We reject this argument because it analogizes workers' compensation cases to tort cases. The analogy is inapt. Workers' compensation schemes generally determine recovery on the basis of a rigid formula, often with a statutory maximum. See Larson, The Law of Workmen's Compensation, Vol. 1, S 1.10 at 1-2, S 2.20 at 1-10 (1993). Apportionment in workers' compensation settlements therefore involves a relatively simple comparison of the total settlement to the measure of damages allowed for individual components of the settlement, pursuant to a prescribed formula. Tort cases, in contrast, involve noneconomic damages not available in workers' compensation cases, and a victim's damages are not determined by an established formula. Apportionment of Medicare's recovery in tort cases would either require a factfinding process to determine actual damages or would place Medicare at the mercy of a victim's or personal injury attorney's estimate of damages.

CONCLUSION

The MSP legislation is unclear as to whether HHS is entitled to full reimbursement of conditional Medicare payments when a beneficiary receives a discounted settlement from a third party. HHS has construed the legislation to permit it to recover up to the full amount of its conditional Medicare payments. This is a permissible construction of the statute. Accordingly, we uphold this construction, and affirm the district court's summary judgment in favor of HHS.

AFFIRMED.

Footnotes

[Footnote 1] HHS is required by the Social Security Act to waive recovery in cases where recovery would cause financial hardship to the beneficiary or otherwise be "against equity and good conscience." 42 C.F.R. S 1395gg(c). See also 42 C.F.R. S 411.28. There is no issue of waiver before us. We mention it only because HHS concedes that the waiver provisions of 42 U.S.C. S 1395gg(c) and 42 C.F.R. S 411.28 act as a safety valve to provide relief from an otherwise harsh or inequitable result.

Texas Administrative Code

TITLE 25 HEALTH SERVICES

PART 1 TEXAS DEPARTMENT OF HEALTH

CHAPTER 28 MEDICAID THIRD PARTY RECOVERY

Subchapters

SUBCHAPTER A .GENERAL PROVISIONS

SUBCHAPTER B APPLICANT AND RECIPIENT REQUIREMENTS

SUBCHAPTER C PROVIDER REQUIREMENTS

SUBCHAPTER D DUTIES OF THE DEPARTMENT

SUBCHAPTER E HEALTH INSURER REQUIREMENTS

Texas Administrative Code

TITLE 25 HEALTH SERVICES

PART 1 TEXAS DEPARTMENT OF HEALTH

CHAPTER 28 MEDICAID THIRD PARTY RECOVERY

SUBCHAPTER B APPLICANT AND RECIPIENT REQUIREMENTS

RULE §§28.203 Duty of Attorney or Representative of a Recipient

(a) An attorney or other person who represents or acts on behalf of a recipient in a third party claim or action for damages for personal injuries, regardless of whether a legal action has been filed, for which medical services are provided and paid for by Medicaid must send written notice of representation to the department. The written notice must be signed by the attorney or representative of the recipient and sent to the address listed in Subchapter D of this chapter for notices and department contact. The written notice must be submitted within 45 days from the date the attorney or representative undertakes representation of the recipient, or from the date a potential third party is identified. The written notice must include the following information, if known at the time of initial filing:

(1) the name and address and identifying information of the recipient (either the date of birth and the Social Security number, or the date of birth and the Medicaid identification number);

(2) the name and address of any third party or third party health insurer against whom a third party claim is or may be asserted for injuries to the Medicaid applicant or recipient;

(3) the name and address of any health care provider who has asserted a claim for payment provided to the Medicaid applicant or recipient for medical services provided to the Medicaid applicant or recipient for which a third party may be liable for payment, whether or not the claim may have been submitted to or paid by the department; and

(4) if any of the information described in subsection (a) of this section is unknown at the time the initial notice is filed, this should be indicated on the notice, and revised if and when the information becomes known.

(b) An authorization to release information relating to the recipient directly to the attorney or representative may be included as a part of the notice and must be signed by the recipient. A notice containing an authorization for release of information will be considered valid until revoked in writing by the recipient, and no separate authorization will be required of the recipient or the attorney or the representative at the time of a request for information.

(c) Any settlement, trust, judgment, order or distribution of proceeds which is required to be disclosed to the department to carry out the purpose of this chapter is protected from further disclosure by the department or its agents under the provisions of the Social Security Act, §§1902(a)(7) (codified at 42 U.S.C 1396a(a)(7)), relating to restrictions on information disclosure).

(d) The department must be paid all amounts owed under this chapter prior to placing any proceeds from a third party into a trust created under the provisions of the Social Security Act §§1917(d)(4) (codified at 42 U.S.C 1396p(d)(4)), unless the department agrees otherwise.

Source Note: The provisions of this §§28.203 adopted to be effective April 30, 1999, 24 TexReg 3083

Texas Administrative Code

TITLE 40	SOCIAL SERVICES AND ASSISTANCE
PART 1	TEXAS DEPARTMENT OF HUMAN SERVICES
CHAPTER 15	MEDICAID ELIGIBILITY
SUBCHAPTER B	MEDICARE AND THIRD-PARTY RESOURCES
RULE §§15.215	**Third-party Resources (TPRs)**

(a) TPRs must be applied toward the client's medical and health expenses. Medicaid is usually the payor of last resort.

(b) TPRs include the following:

(1) Individual or group health insurance. Health insurance policies include individual or group contracts and commercial hospital, medical, and surgical policies. A client may have medical insurance coverage from current employment, residual coverage from previous employment, or private insurance paid for by the client or a relative. A client's relative may have personal or group insurance that covers the client's medical expenses.

(2) Government health insurance. Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) is available to dependent children and spouses of active, retired, and deceased military services personnel. Parts A and B of Medicare provide a TPR for Medicaid clients entitled to Medicare.

(3) Liability or casualty insurance and court settlements. Accidental injuries may result in third parties being liable for medical expenses. The usual sources of payment for medical expenses in these situations are automobile insurance; homeowners insurance; owners, landlords, and tenants insurance; workers' compensation; and lawsuit settlements.

(4) Direct providers. Direct providers are resources that provide the actual medical care at no cost to the client. These include VA facilities, public clinics, and health maintenance organizations (HMOs).

(5) Long-term care insurance policies.

(A) Long-term care insurance policies pay for nursing facility care. Benefits are specified in the policy

purchased by the client.

(B) Long-term care insurance policies do not affect Medicaid eligibility. If a client has such a policy, the eligibility specialist reports it as a third-party resource, using a Medical Insurance Input form.

(c) Persons applying for Medicaid automatically assign to the department their rights of recovery from TPRs to the extent that the department pays for the service. Medicaid clients must report to the department any TPR within 60 days of learning about the coverage or liability.

(d) The two methods for using TPRs are:

(1) cost avoidance, in which available benefits are applied before Medicaid payment is made; and

(2) post-payment recovery, in which Medicaid pays the medical costs before seeking reimbursement. A client must reimburse the department as soon as he receives the third-party payment for medical services already paid by Medicaid.

(e) Health insurance premium payment reimbursement program (HIPP). Once National Heritage Insurance Company (NHIC) has determined that the client's employer-based health insurance is cost-effective, participation in HIPP becomes a condition of eligibility. Denial of all benefits will result if the client voluntarily drops the coverage or fails to provide NHIC with the information needed to determine cost effectiveness.

Source Note: The provisions of this §§15.215 adopted to be effective April 17, 1989, 14 TexReg 1083; amended to be effective October 1, 1995, 20 TexReg 7377; amended to be effective February 1, 1996, 21 TexReg 262.

Texas Administrative Code

TITLE 40 SOCIAL SERVICES AND ASSISTANCE

PART 1 TEXAS DEPARTMENT OF HUMAN SERVICES

CHAPTER 79 LEGAL SERVICES

SUBCHAPTER R MEDICAID THIRD-PARTY RECOVERY

RULE §§79.1701 **Basis and Purpose**

(a) This section implements the obligation of the Texas Department of Human Services (DHS) under federal and state law to:

(1) set forth the requirements of Medicaid applicants and recipients, and representatives of applicants and recipients, regarding assignment of causes of action against third parties, or their insurer(s), responsible for injury to the applicant or recipient that requires medical care and/or services for which the third party or the third party's insurer is legally obligated to pay; and

(2) establish the priority of distributions of third-party recoveries among DHS, the federal government, and the recipient.

(b) This chapter does not address DHS's right of recovery under:

(1) §§1917(d)(4) of the Social Security Act (codified at 42 U.S.C. §§1396p(d)(4)); or

(2) third-party contracts with insurers obligated to pay for health care for the recipient.

Source Note: The provisions of this §§79.1701 adopted to be effective August 1, 2000, 25 TexReg 6779

Texas Administrative Code

TITLE 40 SOCIAL SERVICES AND ASSISTANCE

PART 1 TEXAS DEPARTMENT OF HUMAN SERVICES

CHAPTER 79 LEGAL SERVICES

SUBCHAPTER R MEDICAID THIRD-PARTY RECOVERY

RULE §§79.1703 Distribution of Recoveries

(a) The Texas Department of Human Services (DHS) will distribute third-party recoveries as follows:

(1) DHS will receive an amount equal to DHS's Medicaid expenditures for the recipient or for another

individual eligible for Medicaid benefits under the State Plan for whom the recipient can legally make an assignment to medical support and payment;

(2) the federal government will receive the federal share of the Medicaid expenditures, minus any incentive payment authorized by federal law; and

(3) the recipient will receive any remaining amount. Any amount distributed to the recipient is income or resources for purposes of establishing eligibility for Medicaid benefits.

(b) DHS may pay reasonable and necessary attorney fees of 15% of the entire amount recovered on behalf of DHS, and reasonable expenses, to a person authorized to recover amounts from third parties, other than a person contracted by DHS to recover on behalf of DHS, if the recovery is made in compliance with this subchapter.

(c) DHS may pay prorated expenses, not to exceed 10% of the entire amount recovered on behalf of DHS, if attorney fees are allowed under subsection (b) of this section.

(d) No attorney fees will be paid if the recovery made on behalf of the Medicaid program is waived in whole or in part by the commissioner under the provisions of §§32.033(f) of the Human Resources Code and §§79.1704 of this title (relating to Waiver Authority of the Commissioner).

(e) The amount recovered on behalf of DHS for which attorney fees are authorized under this section must be deducted from the total amount of the recovery before attorney fees and expenses are deducted under the terms of the recipient's contract.

(f) DHS may pay reasonable and necessary attorney fees and expenses to a person contracted by DHS to recover amounts from third parties on behalf of the Medicaid program.

Source Note: The provisions of this §§79.1703 adopted to be effective August 1, 2000, 25 TexReg 6779

United States Code

TITLE 42 - THE PUBLIC HEALTH AND WELFARE

CHAPTER 7 - SOCIAL SECURITY

SUBCHAPTER XIX - GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

U.S. Code as of: 01/05/99 **Section 1396p. Liens, adjustments and recoveries, and transfers of assets**

(a) Imposition of lien against property of an individual on account of medical assistance rendered to him under a State plan

(1) No lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State plan, except -

(A) pursuant to the judgment of a court on account of benefits incorrectly paid on behalf of such individual, or

(B) in the case of the real property of an individual -

(i) who is an inpatient in a nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of his income required for personal needs, and

(ii) with respect to whom the State determines, after notice and opportunity for a hearing (in accordance with procedures established by the State), that he cannot reasonably be expected to be discharged from the medical institution and to return home,

except as provided in paragraph (2).

(2) No lien may be imposed under paragraph (1)(B) on such individual's home if -

(A) the spouse of such individual,

(B) such individual's child who is under age 21, or (with respect to States eligible to participate in the State program established under subchapter XVI of this chapter) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1382c of this title, or

(C) a sibling of such individual (who has an equity interest in such home and who was residing in such individual's home for a period of at least one year immediately before the date of the individual's admission to the medical institution),

is lawfully residing in such home.

(3) Any lien imposed with respect to an individual pursuant to paragraph (1)(B) shall dissolve upon that individual's discharge from the medical institution and return home.

(b) Adjustment or recovery of medical assistance correctly paid under a State plan

(1) No adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan may be made, except that the State shall seek adjustment or recovery of any

medical assistance correctly paid on behalf of an individual under the State plan in the case of the following individuals:

(A) In the case of an individual described in subsection (a)(1)(B) of this section, the State shall seek adjustment or recovery from the individual's estate or upon sale of the property subject to a lien imposed on account of medical assistance paid on behalf of the individual.

(B) In the case of an individual who was 55 years of age or older when the individual received such medical assistance, the State shall seek adjustment or recovery from the individual's estate, but only for medical assistance consisting of -

(i) nursing facility services, home and community-based services, and related hospital and prescription drug services, or

(ii) at the option of the State, any items or services under the State plan.

(C)(i) In the case of an individual who has received (or is entitled to receive) benefits under a long-term care insurance policy in connection with which assets or resources are disregarded in the manner described in clause (ii), except as provided in such clause, the State shall seek adjustment or recovery from the individual's estate on account of medical assistance paid on behalf of the individual for nursing facility and other long-term care services.

(ii) Clause (i) shall not apply in the case of an individual who received medical assistance under a State plan of a State which had a State plan amendment approved as of May 14, 1993, which provided for the disregard of any assets or resources -

(I) to the extent that payments are made under a long-term care insurance policy; or

(II) because an individual has received (or is entitled to receive) benefits under a long-term care insurance policy.

(2) Any adjustment or recovery under paragraph (1) may be made only after the death of the individual's surviving spouse, if any, and only at a time -

(A) when he has no surviving child who is under age 21, or (with respect to States eligible to participate in the State program established under subchapter XVI of this chapter) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is

blind or disabled as defined in section 1382c of this title; and
(B) in the case of a lien on an individual's home under subsection (a)(1)(B) of this section, when -
(i) no sibling of the individual (who was residing in the individual's home for a period of at least one year immediately before the date of the individual's admission to the medical institution), and
(ii) no son or daughter of the individual (who was residing in the individual's home for a period of at least two years immediately before the date of the individual's admission to the medical institution, and who establishes to the satisfaction of the State that he or she provided care to such individual which permitted such individual to reside at home rather than in an institution),
is lawfully residing in such home who has lawfully resided in such home on a continuous basis since the date of the individual's admission to the medical institution.
(3) The State agency shall establish procedures (in accordance with standards specified by the Secretary) under which the agency shall waive the application of this subsection (other than paragraph (1)(C)) if such application would work an undue hardship as determined on the basis of criteria established by the Secretary.
(4) For purposes of this subsection, the term "estate", with respect to a deceased individual -
(A) shall include all real and personal property and other assets included within the individual's estate, as defined for purposes of State probate law; and
(B) may include, at the option of the State (and shall include, in the case of an individual to whom paragraph (1)(C)(i) applies), any other real and personal property and other assets in which the individual had any legal title or interest at the time of death (to the extent of such interest), including such assets conveyed to a survivor, heir, or assign of the deceased individual through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement.
(c) Taking into account certain transfers of assets
(1)(A) In order to meet the requirements of this subsection for purposes of section 1396a(a)(18) of this title, the State plan must provide that if an institutionalized individual or the spouse of

such an individual (or, at the option of a State, a noninstitutionalized individual or the spouse of such an individual) disposes of assets for less than fair market value on or after the look-back date specified in subparagraph (B)(i), the individual is ineligible for medical assistance for services described in subparagraph (C)(i) (or, in the case of a noninstitutionalized individual, for the services described in subparagraph (C)(ii)) during the period beginning on the date specified in subparagraph (D) and equal to the number of months specified in subparagraph (E).

(B)(i) The look-back date specified in this subparagraph is a date that is 36 months (or, in the case of payments from a trust or portions of a trust that are treated as assets disposed of by the individual pursuant to paragraph (3)(A)(iii) or (3)(B)(ii) of subsection (d) of this section, 60 months) before the date specified in clause (ii).

(ii) The date specified in this clause, with respect to -

(I) an institutionalized individual is the first date as of which the individual both is an institutionalized individual and has applied for medical assistance under the State plan, or

(II) a noninstitutionalized individual is the date on which the individual applies for medical assistance under the State plan or, if later, the date on which the individual disposes of assets for less than fair market value.

(C)(i) The services described in this subparagraph with respect to an institutionalized individual are the following:

(I) Nursing facility services.

(II) A level of care in any institution equivalent to that of nursing facility services.

(III) Home or community-based services furnished under a waiver granted under subsection (c) or (d) of section 1396n of this title.

(ii) The services described in this subparagraph with respect to a noninstitutionalized individual are services (not including any services described in clause (i)) that are described in paragraph (7), (22), or (24) of section 1396d(a) of this title, and, at the option of a State, other long-term care services for which medical assistance is otherwise available under the State plan to individuals requiring long-term care.

(D) The date specified in this subparagraph is the first day of

the first month during or after which assets have been transferred for less than fair market value and which does not occur in any other periods of ineligibility under this subsection.

(E)(i) With respect to an institutionalized individual, the number of months of ineligibility under this subparagraph for an individual shall be equal to -

(I) the total, cumulative uncompensated value of all assets transferred by the individual (or individual's spouse) on or after the look-back date specified in subparagraph (B)(i), divided by

(II) the average monthly cost to a private patient of nursing facility services in the State (or, at the option of the State, in the community in which the individual is institutionalized) at the time of application.

(ii) With respect to a noninstitutionalized individual, the number of months of ineligibility under this subparagraph for an individual shall not be greater than a number equal to -

(I) the total, cumulative uncompensated value of all assets transferred by the individual (or individual's spouse) on or after the look-back date specified in subparagraph (B)(i), divided by

(II) the average monthly cost to a private patient of nursing facility services in the State (or, at the option of the State, in the community in which the individual is institutionalized) at the time of application.

(iii) The number of months of ineligibility otherwise determined under clause (i) or (ii) with respect to the disposal of an asset shall be reduced -

(I) in the case of periods of ineligibility determined under clause (i), by the number of months of ineligibility applicable to the individual under clause (ii) as a result of such disposal, and

(II) in the case of periods of ineligibility determined under clause (ii), by the number of months of ineligibility applicable to the individual under clause (i) as a result of such disposal.

(2) An individual shall not be ineligible for medical assistance by reason of paragraph (1) to the extent that -

(A) the assets transferred were a home and title to the home was transferred to -

(i) the spouse of such individual;

(ii) a child of such individual who (I) is under age 21, or
(II) (with respect to States eligible to participate in the
State program established under subchapter XVI of this chapter)
is blind or permanently and totally disabled, or (with respect
to States which are not eligible to participate in such
program) is blind or disabled as defined in section 1382c of
this title;
(iii) a sibling of such individual who has an equity interest
in such home and who was residing in such individual's home for
a period of at least one year immediately before the date the
individual becomes an institutionalized individual; or
(iv) a son or daughter of such individual (other than a child
described in clause (ii)) who was residing in such individual's
home for a period of at least two years immediately before the
date the individual becomes an institutionalized individual,
and who (as determined by the State) provided care to such
individual which permitted such individual to reside at home
rather than in such an institution or facility;
(B) the assets -
(i) were transferred to the individual's spouse or to another
for the sole benefit of the individual's spouse,
(ii) were transferred from the individual's spouse to another
for the sole benefit of the individual's spouse,
(iii) were transferred to, or to a trust (including a trust
described in subsection (d)(4) of this section) established
solely for the benefit of, the individual's child described in
subparagraph (A)(ii)(II), or
(iv) were transferred to a trust (including a trust described
in subsection (d)(4) of this section) established solely for
the benefit of an individual under 65 years of age who is
disabled (as defined in section 1382c(a)(3) of this title);
(C) a satisfactory showing is made to the State (in accordance
with regulations promulgated by the Secretary) that (i) the
individual intended to dispose of the assets either at fair
market value, or for other valuable consideration, (ii) the
assets were transferred exclusively for a purpose other than to
qualify for medical assistance, or (iii) all assets transferred
for less than fair market value have been returned to the
individual; or
(D) the State determines, under procedures established by the

State (in accordance with standards specified by the Secretary), that the denial of eligibility would work an undue hardship as determined on the basis of criteria established by the Secretary; (FOOTNOTE 1)

(FOOTNOTE 1) So in original. The semicolon probably should be a period.

(3) For purposes of this subsection, in the case of an asset held by an individual in common with another person or persons in a joint tenancy, tenancy in common, or similar arrangement, the asset (or the affected portion of such asset) shall be considered to be transferred by such individual when any action is taken, either by such individual or by any other person, that reduces or eliminates such individual's ownership or control of such asset.

(4) A State (including a State which has elected treatment under section 1396a(f) of this title) may not provide for any period of ineligibility for an individual due to transfer of resources for less than fair market value except in accordance with this subsection. In the case of a transfer by the spouse of an individual which results in a period of ineligibility for medical assistance under a State plan for such individual, a State shall, using a reasonable methodology (as specified by the Secretary), apportion such period of ineligibility (or any portion of such period) among the individual and the individual's spouse if the spouse otherwise becomes eligible for medical assistance under the State plan.

(5) In this subsection, the term "resources" has the meaning given such term in section 1382b of this title, without regard to the exclusion described in subsection (a)(1) thereof.

(d) Treatment of trust amounts

(1) For purposes of determining an individual's eligibility for, or amount of, benefits under a State plan under this subchapter, subject to paragraph (4), the rules specified in paragraph (3) shall apply to a trust established by such individual.

(2)(A) For purposes of this subsection, an individual shall be considered to have established a trust if assets of the individual were used to form all or part of the corpus of the trust and if any of the following individuals established such trust other than by will:

(i) The individual.

(ii) The individual's spouse.

(iii) A person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse.
(iv) A person, including any court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.
(B) In the case of a trust the corpus of which includes assets of an individual (as determined under subparagraph (A)) and assets of any other person or persons, the provisions of this subsection shall apply to the portion of the trust attributable to the assets of the individual.
(C) Subject to paragraph (4), this subsection shall apply without regard to -
(i) the purposes for which a trust is established,
(ii) whether the trustees have or exercise any discretion under the trust,
(iii) any restrictions on when or whether distributions may be made from the trust, or
(iv) any restrictions on the use of distributions from the trust.
(3)(A) In the case of a revocable trust -
(i) the corpus of the trust shall be considered resources available to the individual,
(ii) payments from the trust to or for the benefit of the individual shall be considered income of the individual, and
(iii) any other payments from the trust shall be considered assets disposed of by the individual for purposes of subsection (c) of this section.
(B) In the case of an irrevocable trust -
(i) if there are any circumstances under which payment from the trust could be made to or for the benefit of the individual, the portion of the corpus from which, or the income on the corpus from which, payment to the individual could be made shall be considered resources available to the individual, and payments from that portion of the corpus or income -
(I) to or for the benefit of the individual, shall be considered income of the individual, and
(II) for any other purpose, shall be considered a transfer of assets by the individual subject to subsection (c) of this section; and

(ii) any portion of the trust from which, or any income on the corpus from which, no payment could under any circumstances be made to the individual shall be considered, as of the date of establishment of the trust (or, if later, the date on which payment to the individual was foreclosed) to be assets disposed by the individual for purposes of subsection (c) of this section, and the value of the trust shall be determined for purposes of such subsection by including the amount of any payments made from such portion of the trust after such date.

(4) This subsection shall not apply to any of the following trusts:

(A) A trust containing the assets of an individual under age 65 who is disabled (as defined in section 1382c(a)(3) of this title) and which is established for the benefit of such individual by a parent, grandparent, legal guardian of the individual, or a court if the State will receive all amounts remaining in the trust upon the death of such individual up to an amount equal to the total medical assistance paid on behalf of the individual under a State plan under this subchapter.

(B) A trust established in a State for the benefit of an individual if -

(i) the trust is composed only of pension, Social Security, and other income to the individual (and accumulated income in the trust),

(ii) the State will receive all amounts remaining in the trust upon the death of such individual up to an amount equal to the total medical assistance paid on behalf of the individual under a State plan under this subchapter; and

(iii) the State makes medical assistance available to individuals described in section 1396a(a)(10)(A)(ii)(V) of this title, but does not make such assistance available to individuals for nursing facility services under section 1396a(a)(10)(C) of this title.

(C) A trust containing the assets of an individual who is disabled (as defined in section 1382c(a)(3) of this title) that meets the following conditions:

(i) The trust is established and managed by a non-profit association.

(ii) A separate account is maintained for each beneficiary of the trust, but, for purposes of investment and management of

funds, the trust pools these accounts.
(iii) Accounts in the trust are established solely for the benefit of individuals who are disabled (as defined in section 1382c(a)(3) of this title) by the parent, grandparent, or legal guardian of such individuals, by such individuals, or by a court.
(iv) To the extent that amounts remaining in the beneficiary's account upon the death of the beneficiary are not retained by the trust, the trust pays to the State from such remaining amounts in the account an amount equal to the total amount of medical assistance paid on behalf of the beneficiary under the State plan under this subchapter.

(5) The State agency shall establish procedures (in accordance with standards specified by the Secretary) under which the agency waives the application of this subsection with respect to an individual if the individual establishes that such application would work an undue hardship on the individual as determined on the basis of criteria established by the Secretary.

(6) The term "trust" includes any legal instrument or device that is similar to a trust but includes an annuity only to such extent and in such manner as the Secretary specifies.

(e) Definitions

In this section, the following definitions shall apply:

(1) The term "assets", with respect to an individual, includes all income and resources of the individual and of the individual's spouse, including any income or resources which the individual or such individual's spouse is entitled to but does not receive because of action -
(A) by the individual or such individual's spouse,
(B) by a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or such individual's spouse, or
(C) by any person, including any court or administrative body, acting at the direction or upon the request of the individual or such individual's spouse.

(2) The term "income" has the meaning given such term in section 1382a of this title.

(3) The term "institutionalized individual" means an individual who is an inpatient in a nursing facility, who is an inpatient in a medical institution and with respect to whom

payment is made based on a level of care provided in a nursing facility, or who is described in section 1396a(a)(10)(A)(ii)(VI) of this title.

(4) The term "noninstitutionalized individual" means an individual receiving any of the services specified in subsection (c)(1)(C)(ii) of this section.

(5) The term "resources" has the meaning given such term in section 1382b of this title, without regard (in the case of an institutionalized individual) to the exclusion described in subsection (a)(1) of such section.

Medicare Intermediary Manual § 3418.8.

3418.8 Calculation of Medicare's Claim and Procurement Expenses (When Liability Insurer Paid Beneficiary).--

1. A. Allegation of Pre-existing Conditions.--In some cases, the amount of the overpayment is questioned on the grounds that services included in the calculation were for pre-existing conditions and should be omitted from the overpayment calculation.

When a beneficiary has filed suit for accident-related services, including services relating to exacerbation of an underlying condition as the basis for the complaint, the total amount of Medicare's payments should be used to calculate the amount of Medicare's recovery. The fact that the settlement or other documentation provides that all parties considered such services to be unrelated to the accident or injuries, does not justify omitting them from Medicare's recovery.

B. Calculating Medicare's Share of Procurement Costs.--42 CFR 411.37©) stipulates that Medicare will recognize a proportionate share of the necessary procurement costs incurred in obtaining the settlement. Procurement costs are those costs incurred in obtaining a judgment or settlement (e.g. court costs, attorney fees). If a beneficiary is paid by a liability insurer, recover Medicare's payment from the beneficiary, reduced by a proportionate share of the beneficiary's procurement costs, if any.

If, under the Prospective Payment System (PPS), Medicare pays a provider more than its charges, do not recover more than the charges from a beneficiary's liability settlement. (Under Medicare regulations, a beneficiary who must refund a Medicare payment made to a provider is liable only to the extent that he or she benefitted from the payment. Since the beneficiary would have had to pay only the provider's charges in the absence of Medicare, the beneficiary is not liable for refunding more than the charges.) The provider is not required to refund the excess of the Medicare payment rate over the provider's charges.

To determine procurement costs, ask the attorney to furnish (in writing) the costs, including attorney fees, incurred by the individual to procure the settlement/judgment. If these costs appear in excess of the prevailing costs in the area for similar claims, ask for an itemized statement of costs or copy of a contingency agreement, if applicable, or other appropriate documentation. If the procurement costs are documented, allow them. Should you need advice on what constitutes procurement costs in a particular case, consult your legal counsel or the RO. (Also, see definition of procurement costs in §3418.2.M.)
Use the following formula to determine the amount of Medicare's claim when there are procurement costs:

1. Determine the ratio which the procurement costs bear to the amount of the liability payment or settlement.

2. Apply this ratio to the Medicare payments; and

3. Subtract the amount determined from b) above from the lesser of the total conditional payments or the providers' charges. The remainder is the amount to be refunded to the Medicare program. (You may round this amount to the nearest dollar.)

Exhibit 1- Medicare Liability Settlement Claim Reimbursement Summary, provides a worksheet for use in calculating procurement costs, Medicare's share of procurement costs, and Medicare's claim to be recovered.

NOTE: If Medicare payments equal or exceed the amount of the liability insurance payment, recover the entire liability insurance payment up to the providers' charges, less total procurement costs.

***Medicare Intermediary Manual* § 3418.10**

C. Release Agreement Form.--Once the beneficiary agrees to pay Medicare the amount that Medicare will accept in satisfaction of its claim (full amount, or amount remaining after an appeal or waiver determination), it is your responsibility to obtain the appropriate signatures on a general release after the settlement. A general release as applied to Medicare is an agreement which waives Medicare's right to change the amount of money it is accepting in satisfaction of its claim, and precludes Medicare from later asserting a claim against any outstanding amount not included in the satisfaction, e.g., monies remaining in the case of a partial waiver (See Exhibit 7 - Release Agreement Form.) The beneficiary agrees to the amount in question and is released from further obligation to repay. Medicare has no obligation to pay for any services related to the injury furnished before the date of the settlement which were not brought to Medicare's attention in writing before the settlement was reached.

1. This form should be signed either a) when the beneficiary agrees to remit in full, or b) after final disposition of a waiver/appeal request. The RO is responsible for securing a release for claims compromised under FCCA.

1. MEDICARE LIABILITY SETTLEMENT CLAIM REIMBURSEMENT SUMMARY

Beneficiary: ____________________________ HICN: ____________________

1. Amount of settlement $ ____________________

2. Medicare payments
(contractor) $ ____________________

(contractor) $ ____________________

(contractor) $ ____________________

3. Total Medicare payments $ ____________________

4. Attorney fees (____% of line
1, if applicable) $ ____________________

5. Other procurement costs incurred
(per attorney) $ ____________________

6. Total procurement costs
(lines 4 + 5) $ ____________________

7. Ratio of procurement costs to
settlement (line 6 / line 1) ____________________%

8. Medicare's share of procurement
costs (line 3 x 7) $ ____________________

9. Total Providers' Charges $ ____________________

10. Medicare's claim to be recovered
(the lesser of line 3 or line 9
minus line 8) $ ____________________

PLEASE PREPARE THE CHECK EXACTLY AS SPECIFIED BELOW

NAME OF CONTRACTOR $ AMOUNT

If any questions arise, please call -- (Name and telephone number of appropriate contractor staff person.)

EXHIBIT 1

1. STANDARD RECOVERY/INITIAL DETERMINATION LETTER TO BENEFICIARY/ATTORNEY

Dear Mr./Ms. ____________________

This letter follows our (date of initial letter to beneficiary/attorney) letter in which we advised you that you would have to pay Medicare back if you received money from a third party due to your (date of accident) accident which caused medical expenses for which Medicare conditionally paid. We have now been advised that you have received such proceeds. This means that Medicare now has a claim against these proceeds in the amount of $_________, which represents Medicare's claim after reduction for procurement costs, in accordance with 42 CFR 411.37.

The Medicare Secondary payer provisions of the statute, 42 CFR 1395y(b)(2), preclude Medicare from paying for a beneficiary's medical expenses when payment "has been made or can reasonably be expected to be made promptly... under an automobile or liability insurance policy or plan (including a self-insured plan) or under no-fault insurance." However, Medicare will pay for a beneficiary's covered medical expenses when the third party payer does not pay promptly, conditioned on reimbursement to contract room proceeds received from a third party liability settlement, award, judgment or recovery. In your case, Medicare made a conditional payment in the amount of $________. A list of the claims used to arrive at this total is enclosed.

Medicare's regulations require that you pay Medicare back within 60 days of your receipt of settlement or insurance proceeds. It is our understanding that 60 days have passed since you received the insurance proceeds. Therefore, please send a check or money order in the amount of $_______, made payable to (name of contactor) in the enclosed envelope.

Exercising common law authority and consistent with the Federal Claims Collection Act and 45 CFR 30.13, interest will be assessed if this debt is not repaid in full within 30 days of the date of this letter. Additionally, 45 CFR 30.14(a) provides that a debtor may either pay the debt, or be liable for interest on the uncorrectable debt while a waiver determination, appeal, or a formal or informal review of the debt is pending. Therefore, assessment of interest may not be suspended solely because further review may be requested. Interest will be assessed at the rate of ________. It should be noted, however, that you may repay the debt to avoid accruing charges, but retain your right to dispute, appeal, or request waiver of the debt. If you succeed in your appeal or waiver request, Medicare will refund your money.

If you do not repay this overpayment, Medicare has the authority to refer it to the Social Security Administration or Railroad Retirement Board for further recovery action, which may result in the overpayment being deducted from any monthly Social Security or Railroad Retirement benefits to which you may be entitled.

EXHIBIT 2

If you are unable to refund this amount in one payment, you may ask us to consider whether to allow you to pay in regular installments.

The law requires that you must repay an overpayment to Medicare unless both of the following conditions are met:

(1) This overpayment was not your fault, because the information you gave us with your claim was correct and complete as far as you knew, and, when the Medicare payment was made, you thought that it was the right payment for your claim,

AND

1. (2) Paying back this money would cause financial hardship **OR** would be unfair for some other reason.

If you believe that **BOTH** of the conditions above apply in your case, please let us know, giving a brief statement of your reasons. You will be sent a form asking for information about your income, assets, and expenses, and requesting that you explain why you believe you are entitled to waiver of the overpayment. We will notify you if recovery of this overpayment can be waived.

You may appeal our decision if: you disagree that you received an overpayment; or you disagree with the amount of overpayment; or you disagree with our decision not to waive your repayment of the overpayment.

For Part A services, you must appeal within 60 days from the date of your receipt of this determination. For Part B services, you must file an appeal within 6 months of the date of this determination. However, we recommend that you file appeals of Part A and Part B claims within 60 days of receiving this notice so that both appeals may be resolved efficiently. Appeals should be requested in writing to _________________.

If you decide to appeal this determination further, and if you want help with your appeal, you can have a friend, lawyer, or someone else help you. Some lawyers do not charge unless you win your appeal. There are groups, such as lawyer referral services, that can help you find a lawyer. There are also groups, such as legal aid services, who will provide free legal services if you qualify.

If you have any questions about this letter, you may contact either this office or any Social Security office.

Sincerely,

ABC Contractor

Attachments: List of claims
Pre-ad

STANDARD LETTER GRANTING PARTIAL WAIVER

1. Re: Name of Beneficiary HIC #

Dear Beneficiary/Attorney:

We have completed our review of your/your client's request to waive monies owed to Medicare. It is our decision to partially waive Medicare's claim.

The authority to waive recovery of a Medicare overpayment is found in Section 1870©) of the Social Security Act (42 U.S.C. 1395gg©)). Under this provision, and the regulations found at 42 CFR 405.355-405.356, if a beneficiary is without fault in causing the overpayment and recovery would either defeat the purpose of the Social Security Act or Medicare program, or would be against equity and good conscience, recovery may be waived. In making these decisions, Medicare applies the rules found in Social Security regulations at 20 CFR 404.506-404.509, 404.510a, and 404.512.

In applying these rules, we found the following:

Enter reasons for partial deductions:

Example: This partial waiver is granted because it would be against equity and good conscience to recover the full amount of the claim. The settlement proceeds in this particular case were very small considering the injuries suffered; therefore, it would be against equity and good conscience for Medicare to take the entire settlement.

OR

Example: You have documented financial hardship and we have determined that it would defeat the purpose of the Social Security Act to request repayment of the entire claim. Therefore, we are granting a partial waiver in the amount of __________, and _______ must be repaid to Medicare.

Medicare's conditional payment in this case was __________. You (your client) received a settlement of $___________. The procurement costs in this case, including attorney fees were $_____________. After allowing $___________ as Medicare's share of procurement costs per 42 CFR 411.37, Medicare's net conditional claim was $___________.

However, in accordance with this determination, we are granting a partial waiver in the amount of __________. The total amount now due to Medicare is $(principle and interest). In accordance with this determination, a check in the amount of $___________, made payable to Medicare, should be sent to:

Medicare contractor
Address

Your/the beneficiary's name and health insurance claim number should be included on the check made payable to Medicare.

On (date that exhibit 2 was sent)______, we notified you that interest would be assessed on any debt not repaid in full within 30 days of that date, regardless of whether you chose to appeal or to seek waiver of the debt. We advised you that repaying the debt would not affect your right to dispute, appeal, or request waiver of the debt. Because you did

not repay the debt within 30 days of (the date that exhibit 2 was sent), you owe Medicare $______, in interest charges.

1. Please sign the enclosed release agreement form within 10 days and return it to this office.

If you disagree with the decision not to grant a full waiver of recovery of this overpayment, you have 60 days from the date you receive this letter to request a reconsideration. The request can be submitted directly to the address above.

If you decide to exercise your appeal rights, and if you want help with your appeal, you can have a friend, lawyer, or someone else help you. There are groups, such as lawyer referral services and public interest advocacy groups, that can help you find a lawyer. There are also groups, such as legal aide services, who provide free legal services if you meet eligibility requirements. Should you/your client have any questions concerning this letter, please contact ________________ on ____________.

Medicare Contractor

Enclosure(s): Release Agreement Form
Pre-addressed envelope

RELEASE AGREEMENT FORM

1. (Name, title and name of contractor) , as a Medicare intermediary or carrier authorized to make the following statements and assurances on behalf of Medicare. The undersigned beneficiary, (name of beneficiary) , is the claimant in an action resulting from an accident which occurred on or about (Date of accident) .

Medicare has been advised of a (proposed) settlement in the above action in the amount of $____________. In accordance with Federal Regulations at 42 CFR 411.37, the amount of funds to be recovered by Medicare pursuant to Section 1862(b)(2) of the Social Security Act (42 U.S.C. 1395y(b)(2)) has been determined to be $______. Medicare and the undersigned beneficiary have agreed that Medicare will accept $___________ in full satisfaction of its claim.

(Name, title and name of contractor) , on behalf of Medicare, does forever discharge (name of beneficiary) , his/her agents, successors, executors, administrators and assigns from any and all claims, actions, causes of action, demands, rights, damages, costs, loss of service, expenses, and compensation whatsoever, which Medicare now has or which may hereafter accrue related to the incident above.

(Name of beneficiary) does forever discharge Medicare, its agents, successors and assigns from any liability for payment for claims related to the incident above and does specifically waive any and all rights to appeal, waiver or [further] compromise of Medicare's interest in claims for items or services related to the incident above.

Medicare has no liability or obligation to pay for any services related to the injury that were furnished before the date of the settlement and that the beneficiary did not specifically identify to Medicare in writing before the release was executed.

Each of the undersigned has read the foregoing release and fully understands it and its terms.

Date: ________________

_________________________ ______________________
(Witness) (Name & Title)
_________________________ Medicare
(Witness)

Date: ________________

_________________________ ______________________
(Witness) (Name of Beneficiary)
_________________________ Beneficiary/Claimant
(Witness)

EXHIBIT 7

1. NOTICE TO BENEFICIARY OF MEDICARE'S POTENTIAL RECOVERY

Dear Beneficiary:

Our records indicate that the medical services you received on [date(s)] were the kind that are often the result of an accident or injury. If this is the case, Medicare recognizes that you might file a claim against the persons you believe should be financially responsible for your accident/injury. If you file such a liability claim, they may pay you a sum of money as a remedy for your injuries and associated costs. Also, your own automobile insurance or homeowner's policy, or other type of insurance, may pay for your medical expenses.

The purpose of this notice is to tell you that Medicare will pay for the medical expenses arising from this accident/injury only on the condition that you pay Medicare back out of any money that you receive from the person or insurance company that compensates you for your damages and losses, including your own insurance company.

This conditional payment that Medicare makes for your accident-related expenses and Medicare's right to reimbursement from your settlement proceeds is the law. It is known as the Medicare Secondary Payer provisions, and can be found at 42 U.S.C. 1395y(b)(2). The rules that govern how this statute operates can be found beginning at 42 CFR 411.20.

This notice is applicable to you only if you receive monies in the future OR have already received monies from a third party or insurance company, or your own insurance company, as a settlement or recovery of a claim you filed (or should have filed) for your injuries, damages, and losses arising from this accident/injury.

Please remember that you are required by law to pay us back as soon as you receive any monies as settlement or recovery of the claim. It is your obligation to let us know when you have settled your claim, no matter how long a time has passed between the original accident/injury and when you receive money.

It is important that you keep in mind the fact that you must pay Medicare back when you, your representative, or attorney negotiates and finally accepts a dollar amount in settlement. This reimbursement should be considered a cost that must be paid up front out of the settlement proceeds before any distribution occurs. Under no circumstances should you spend settlement proceeds which should be used to satisfy Medicare's claim.

If you have engaged an attorney to pursue your liability claim, or are planning to, the amount Medicare may recover will be reduced by a proportional share of attorney fees and/or other procurement costs. If you have a representative or attorney in this matter, give him or her a copy of this notice immediately. If applicable, please advise us of the name and address of your attorney, insurance companies involved, and a description of your injuries on the enclosed HCFA-L365 form, and return it to this office.

EXHIBIT 10

1. NOTICE TO ATTORNEY OF MEDICARE'S POTENTIAL RECOVERY

RE: Mary Smith, HIC# 000-00-0000A
Date of Injury: January 7, 1990

Dear Mr. Adams:

The above Medicare beneficiary has advised us that you have been retained to represent him/her in matters arising out of the above-referenced accident. Medicare acknowledges that you may file a claim and/or a civil action against a third party on [name of beneficiary]'s behalf, seeking damages for injuries he/she received and medical expenses he/she incurred as a result of the accident.

The purpose of this letter is to advise you of the applicability of the Medicare Secondary Payer Program in this circumstance. See 42 U.S.C. 1395y(b)(2). Medicare is precluded from paying for a beneficiary's medical expenses when payment "has been made or can reasonably be expected to be made . . . under an automobile or liability insurance policy or plan (including a self-insured plan) or under no fault insurance." However, Medicare may pay for a beneficiary's covered medical expenses conditioned on reimbursement to Medicare from proceeds received pursuant to a third party liability settlement, award, judgment or recovery. This conditional payment gives Medicare the right to recover its payments when the beneficiary receives proceeds from a third party arising out of an accident which generated the medical expenses for which Medicare conditionally paid.

In these instances, Medicare's reimbursement is reduced by a pro rata share of procurement costs. It is in your, and your client's, best interests to keep Medicare's payment and the obligation to satisfy Medicare's claim in mind when negotiating and accepting a final dollar amount in settlement of the claim with the third party. Medicare's claim must be paid up front out of settlement proceeds before any distribution occurs. Moreover, Medicare must be paid within 60 days of receipt of proceeds from the third party. If Medicare is not repaid timely, interest may be assesses. You may not disburse proceeds up to the amount of Medicare's claim prior to satisfaction or alternative resolution of the matter.

We are coordinating with other Medicare claim offices to obtain a summary of conditional payments made to date. A Medicare contractor will contact you regarding the total amount that Medicare paid for the above-referenced accident-related medical expenses.

If a settlement has already been reached, please provide the following information:

1. An authorization from your client to permit us to release specific claims data to you. If you do not have a release on file, please have your client sign the enclosed release form and return it to our office.

2. A copy of the settlement agreement showing the settlement date and total amount of the award.

3. An itemized statement of attorney fees and procurement costs.

4. The name, address and telephone number of the automobile or liability insurer involved, and if available, the policy number, claim number, and adjustor's name.

Please acknowledge receipt of this letter in writing at your earliest convenience. Should you have any questions regarding this matter, please contact this office at (XXX) XXX-XXXX.

Sincerely,

MSP Coordinator
ABC Contractor

Enclosure: Release of Claims Data Form

EXHIBIT 12